State of Rhode Island and Providence Plantations

Executive Office of Health & Human Services

Sections 0374 and 0375:

Community Supported Living Arrangements
and
Integrated Care Program

Rules and Regulations

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Community Supported Living Arrangements and Integrated Care Program
Medicare and Medicaid Eligible and Medicaid-Only Eligibles
Rules and Regulations

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Medicare and Medicaid Eligible and Medicaid-Only Eligibles

0374 Managed Care Program Options for Adults

0374.05 Legal Authority
REV: May 2014

During the 2005 General Assembly session, the Rhode Island legislature authorized the Rhode Island Medicaid Agency to design managed care programs for adults who are Medicaid members.

Title XIX of the Social Security Act provides the legal authority for the States to administer their Medicaid Programs. The Rhody Health Partners Program, a managed care organization (MCO) model, operates under the authority of Section 1915(a)(1)(A) of the Social Security Act.

Connect Care Choice, which is a primary care case management (PCCM) model, operates under the Federal authority of a section 1932(a) State Plan Amendment.

Under the State's Medicaid Section 1115 demonstration all Medicaid beneficiaries who are eligible as aged, blind or living with a disability[1] are required to enroll in one of the two care management programs: "Connect Care Choice" or "Rhody Health Partners", as described below. When a Connect Care Choice or Rhody Health Partners member becomes eligible for Medicaid long-term services and supports (LTSS), this mandatory enrollment requirement no longer applies. Upon being determined eligible for Medicaid-funded LTSS, the Medicaid beneficiary is disenrolled from Connect Care Choice/Rhody Health Partners and offered the choice of enrolling in Rhody Health Options, Connect Care Choice *Community Partners*, the Program for All-Inclusive Care for the Elderly (PACE), or a fee-for-service (FFS) option.

0374.10 Connect Care Choice - Overview
REV: May 2014

Connect Care Choice (CCC) is a statewide primary care case management model (PCCM) for Medicaid beneficiaries who do not have third-party coverage (Medicare, for example) and choose to use a primary care physician practice that has met EOHHS quality and performance certification standards. Once enrolled, a Medicaid beneficiary is referred to as a "member." Nurse care managers working with the physicians and members ensure effective health care management and coordination of care for members who meet a moderate or high risk score, as determined by the EOHHS. The Medicaid member enrolled in CCC receives primary care from a participating physician or physician practice who provides a medical home to manage the member's chronic care needs and coordinate specialty care. CCC members at moderate or high risk as defined by the EOHHS also receive nurse care management services provided either through the physician practice, or directly contracted by EOHHS.

0374.15 Rhody Health Partners - Overview

Rhody Health Partners is a statewide managed care program for Medicaid-eligible adults, which increases access to health care for adults in the Medicaid Program. Rhody Health Partners offers a

[1] See the Medicaid Code of Administrative Rules (MCAR) sections #0352 ("Characteristic Requirements") and #0376 ("Overview of MA") available online at: www.sos.ri.gov for additional information on eligibility requirements.

comprehensive set of medical, mental health, ancillary and community support services (such as interpreter services) that are accessible, high quality and focused on primary care, specialty care and chronic care management.

Members receiving Medicaid through the Rhody Health Partners option are enrolled in a managed care organization (MCO), which uses a primary care provider to coordinate all medically necessary health care services through an organized delivery system. The EOHHS contracts with MCOs to provide these health services to members.

0374.20 Eligibility for Rhody Partners and Connect Care
REV: May 2014

Rhody Health Partners and the Connect Care Choice Program are available for Medicaid beneficiaries who are:

1. Not covered by other third-party health insurance (including Medicare);
2. Residents of Rhode Island;
3. Individuals not residing in an institution;
4. Age twenty-one (21) and older; and
5. Categorically or medically eligible for Medicaid and medically needy.

0374.25 Program Enrollment

All enrollments into either the Connect Care Choice or Rhody Health Partners Programs are always prospective in nature. There will be no retroactive enrollment into either the Connect Care Choice or the Rhody Health Partners' MCO.

0374.30 Enrollment Process
REV: May 2014

All Medicaid beneficiaries who meet the criteria within either Connect Care Choice or Rhody Health Partners Programs will receive written communications from EOHHS that will explain the options to the beneficiary. A reasonable timeframe will be allowed for the member to make a decision regarding these options.

The beneficiary will be enrolled into a participating Rhody Health Partners MCO or the Connect Care Choice program as the beneficiary has indicated. If a beneficiary does not respond within the allotted timeframe, the individual will be enrolled in either Rhody Health Partners or Connect Care Choice Program, with the option to change programs during the first ninety (90) days.

0374.35 Selection of a Managed Care Option
REV: May 2014

Enrollment in either the Connect Care Choice or the Rhody Health Partners Program is mandatory. Medicaid beneficiaries are required to remain enrolled in one of these programs, but are authorized to transfer from one program to the other once a year during open enrollment. Provided however, should a Connect Care Choice or Rhody Health Partners member become eligible for Medicaid

LTSS, he/she shall be disenrolled from Connect Care Choice/Rhody Health Partners and shall be offered the choice of enrolling in Rhody Health Options, Connect Care Choice *Community Partners*, the Program for All-Inclusive Care for the Elderly (PACE), or a fee-for-service (FFS) option.

0374.40 Auto Re-Assignment after Resumption of Eligibility

REV: May 2014

Medicaid beneficiaries who are disenrolled from Connect Care Choice or Rhody Health Partners due to a loss of eligibility are automatically re-enrolled, or assigned, into the Connect Care Choice Program or their MCO plan, should they regain eligibility within sixty (60) calendar days. If more than sixty (60) calendar days have elapsed, the enrollment process will follow the process in accordance with EOHHS Policy Section 0374.30, Enrollment Process and/or the Medicaid Code of Administrative Rules (MCAR) section 1311, "Enrollment Process: RIte Care and Rhody Health Partners Managed Care Plans."

0374.45 Voluntary Disenrollment by the Member

Connect Care Choice and Rhody Health Partners members may choose to voluntarily disenroll from either the Connect Care Choice Program or the MCO option at any time. The disenrollment from either program will be effective no later than forty-five (45) calendar days after the date on which the written request is received by EOHHS.

0374.50 Member Disenrollment by EOHHS

REV: May 2014

Reasons for EOHHS disenrollment from either the Connect Care Choice or the Rhody Health Partners managed care program participation include but are not limited to:

1. Death;
2. No longer categorically eligible for Medicaid or medically needy;
3. Eligibility error;
4. Loss of program eligibility;
5. Placement in a nursing facility for more than thirty (30) consecutive days for Rhody Health Partners, and more than sixty (60) consecutive days for Connect Care Choice;
6. Placement in Eleanor Slater Hospital;
7. Incarceration;
8. Changed state of residence;
9. The participant obtains third-party health insurance coverage (including Medicare);
10. Eligibility for Medicaid LTSS in the community or in a facility.

0374.55 MCO Requested Member Disenrollment

REV: May 2014

A Rhody Health Partners MCO may request in writing that a member be disenrolled from the MCO because the member's continued enrollment in the Rhody Health Partners MCO seriously impairs the MCO's ability to furnish services to either the particular member or other members. A Rhody Health Partners MCO may not request disenrollment of a member because of:

- An adverse change in the member's health status;
- The member's utilization of medical services; or
- Uncooperative behavior resulting from the member's special needs.

All disenrollments are subject to approval by EOHHS, after an administrative review of the facts of the case has taken place. EOHHS will determine the disenrollment date as appropriate, based on the results of their review.

0374.60 Grievances and Appeals
REV: May 2014

A. Connect Care Choice participants may submit a written request for a fair hearing before the EOHHS Hearing Officer within thirty (30) days of the mailing of the notice of adverse action.

B. Rhody Health Partners members shall exhaust the internal MCO Level I and Level II appeals process before requesting an EOHHS Fair Hearing.

C. The MCO shall maintain internal policies and procedures to conform to state reporting policies, and shall implement a process for logging formal grievances.

D. Appeals filed with an MCO fall into three (3) categories:

1. **Medical Emergency** - An MCO shall decide the appeal within two (2) business days when a treating provider, such as a doctor who takes care of the member, determines the care to be an emergency and all necessary information has been received by the MCO.

2. **Other Medical Care** - The two levels of a non-emergency medical care appeal are as follows:

   a. For the initial level of appeal, the MCO shall decide the appeal within fifteen (15) days of all necessary information being received by the MCO. If the initial decision is adverse to the member, then the MCO shall offer the second level of appeal.

   b. For the second level of appeal, the MCO shall decide on the grievance within fifteen (15) days of all necessary information being received by the MCO.

3. **Non-Medical Care** - If the grievance involves a problem other than medical care, the MCO shall decide the grievance within thirty (30) days of all necessary information being received by the MCO.

E. Rhody Health Partners members may also choose to initiate a third level or “external appeal”, in accordance with the Rhode Island Department of Health’s *Rules and Regulations for the Utilization Review of Health Care Services (R23-17.1-UR).* A member does not have to exhaust the third level appeal before accessing the EOHHS fair hearing process.

Regulations governing the appeals process are found in MCAR Section 0110.

0374.65 Rhody Health Partners Benefits
REV: May 2014

The Rhody Health Partners Program shall provide a comprehensive set of In-Plan Medicaid State Plan benefits, including short-term nursing home stays. In addition, the MCO shall be responsible for the coordination of in-plan services with the case manager of other service delivery systems outside of the MCO.

It shall not be the responsibility of the MCO to provide out-of-plan benefits that are not included in the capitated payment. These services shall be provided by existing Medicaid-approved providers who are reimbursed directly by Medicaid on a FFS basis.

Prescription drugs shall be part of the comprehensive benefit package. For Members of Rhody Health Partners, prescription benefits shall be for generic drugs. Exceptions for limited brand coverage for certain therapeutic classes shall be granted if approved by the EOHHS, or the Managed Care Organizations acting in compliance with their contractual agreements with EOHHS, and in accordance with the criteria described below.

For purposes of approving exceptions to generic-first drug coverage for Medicaid beneficiaries, EOHHS shall determine certain Allowed Brand Name Therapeutic Classes / Single Agents drugs.

EOHHS shall consider the following characteristics of the drug and the clinical conditions under which it is prescribed for purposes of exceptions to generic-first. Review criteria for approval of exceptions to generic-first shall include but not be limited to:

1. Availability of suitable within-class generic substitutes or out-of-class alternatives;
2. Drugs with a narrow therapeutic range that are regarded as the standard of care for treating specific conditions;
3. Relative disruptions in care that may be brought on by changing treatment from one drug to another;
4. Relative medical management concerns for drugs that can only be used to treat patients with specific comorbidities;
5. Relative clinical advantages and disadvantages of drugs within a therapeutic class;
6. Cost differentials between brand and generic alternatives;
7. Drugs that are required under federal and state regulations;
8. Demonstrated medical necessity and lack of efficacy on a case-by-case basis.

0374.70 Mainstreaming / Selective Contracting
REV: May 2014

The mainstreaming of Medicaid beneficiaries into the broader health delivery system is an important objective of the Rhody Health Partners Program. The MCO therefore shall ensure that all of its network providers accept Rhody Health Partners members for treatment. The MCO also shall accept responsibility for ensuring that network providers do not intentionally segregate Rhody Health Partners members in any way from other persons receiving services. MCOs may develop selective contracting arrangements with certain providers for the purpose of cost containment, but shall adhere to the access standards as defined in the MCO contracts.

0374.75 Communities of Care

REV: May 2014

A. The primary goal of Communities of Care (CoC) is to improve access to care and promote member involvement in their care in an effort to decrease non-emergent and avoidable Emergency Department (ED) utilization and associated costs.

B. The target population for CoC is Medicaid beneficiaries who utilize the ED four (4) or more times during the most recent twelve (12) month period. CoC is available to Connect Care Choice (CCC) and Rhody Health Partners (RHP) eligible beneficiaries without other health insurance coverage (e.g., commercial, Medicare, etc). Beneficiaries shall be notified of the requirement to participate in CoC. This notification shall include: program overview, responsibilities, all applicable appeal rights, and duration of services. The EOHHS reserves the right to make exceptions to CoC participation when clinically appropriate.

C. CoC will consist of the following core components:

1. Health Service Utilization Profile;
2. Identification for and Assignment to Restricted Provider Network (i.e., "Lock-In") or Select Provider Referral;
3. Member Outreach and Engagement;
4. Assessment for Care Management and/or Peer Navigator;
5. Development and Implementation of Personal Incentive/ Reward Plan.

0374.75.05 Health Service Utilization Profile

REV: May 2014

The EOHHS, or its contracted Managed Care Organization (MCO), shall create a health service utilization profile for each CoC member based on the services used and determine whether the member is eligible for the Restricted Provider Network or the Select Provider Referral.

0374.75.10 Identification for Restricted Provider Network

REV: May 2014

CoC members who demonstrate one or more of the following utilization patterns/practices within a consecutive 180-day period shall be enrolled in the Restricted Provider Network of CoC:

1. ED visits with three (3) or more Emergency Departments in a consecutive 180-day period;
2. Utilization of four (4) or more primary care providers (PCPs) in a consecutive 180-day period;
3. Utilization of three (3) or more behavioral health providers in a consecutive 180-day period;
4. Prescriptions at six (6) or more pharmacies in a consecutive 180-day period;
5. Received controlled substances from four (4) or more providers in a consecutive 180-day period;
6. A medical billing history during the most recent 180 days that suggests a possible pattern of inappropriate use of medical resources (e.g., conflicting health care services, drugs, or supplies suggesting a pattern of risk);
7. Other relevant patterns that emerge during the utilization profile.

0374.75.10.05 Assignment to Restricted Provider Network

A. CoC members selected for the Restricted Provider Network ("lock-in") shall select the following providers:

1. One PCP;
2. One pharmacy;
3. One narcotic prescriber and/or psychiatric medication prescriber (as appropriate based on Health Utilization Profile and case review);
4. One or more mental health and/or substance abuse providers, as appropriate.

B. CoC members identified for the restricted provider network (lock-in) shall only receive their primary care, narcotic prescription care, pharmacy and behavioral health care from the single provider selected by the member for each of the four provider types noted above.

C. A member may be exempt from assignment to the Restricted Network when clinically appropriate, as determined by EOHHS or its MCO Medical Director, based on further review of the member's health service utilization profile.

D. Members shall be notified of their right to appeal enrollment in the Restricted Provider Network (lock-in).

0374.75.15 Select Provider Referral

CoC members eligible for the Select Provider Network are those who have a complex medical condition or chronic disease and are not assigned to a Restricted Provider Network (lock-in). CoC members who use multiple providers and have one or more complex medical conditions and chronic diseases (e.g., diabetes, chronic obstructive pulmonary disorder, heart failure, asthma, generalized anxiety disorders, depression) shall be referred to the Select Provider Network. The Select Provider Network shall contain providers who have experience serving the elderly, disabled adults, and those with chronic diseases and multiple complex medical conditions.

0374.75.20 Member Outreach and Engagement

REV: May 2014

EOHHS, or its contracted MCO, shall conduct outreach to eligible CoC members to identify reasons why a recipient opts to utilize the Emergency Department for a non-emergent condition, and how that utilization can be avoided in the future. This includes both avoidance of unnecessary ED utilization and improved connections with care providers to avoid acute episodes and improve management of chronic conditions. During outreach, EOHHS or its contracted MCO, shall review the CoC program and the member's rights and responsibilities. This includes explanation of the restricted provider network or the select provider referral and associated appeal rights.

0374.75.25 Care Management / Peer Navigator

Members identified for enrollment in CoC shall be assigned a care manager who shall assist the client in developing an individualized care plan. CoC members may be referred to a peer navigator. The role of the peer navigator is to assist the CoC member in reducing barriers to care, to access medical and nonmedical resources, and to assist the member throughout the care coordination and treatment process.

0374.75.30 Development and Implementation of Plan of Care and Rewards/Incentives
REV: May 2014

Individualized incentive plans will be developed for each CoC member consistent with the individual's care plan in order to reward specific behaviors and achievements consistent with the CoC Program.

The Incentive Plans shall be developed by the member's care manager and/or peer navigator, in conjunction with the member. Members shall be able to select their incentives and rewards, based on a prescribed menu of options, to assure meaningfulness to the reward program.

0374.75.35 Completion of CoC Program Enrollment
REV: May 2014

Completion of participation in CoC shall occur when the following occur:

1. Care plan objectives are achieved;
2. Loss of Medicaid eligibility; or
3. After a minimum of 12 months in the CoC program.

0375 Managed Care Program Options for Integrated Care for Adults with Medicare and Medicaid

0375.05 Legal Authority
REV: May 2014

Pursuant to Public Law 11-151 enacted on June 30, 2011, the Executive Office of Health and Human Services (EOHHS), has engaged in a contractual arrangement for the expansion and integration of care management strategies for Medicaid-only beneficiaries and Medicare and Medicaid eligible (MME) beneficiaries.

Title XIX and XXI of the Social Security Act and other applicable laws and waivers provides the legal authority for states to administer their Medicaid Programs. The Rhody Health Options Program, a managed care organization (MCO) model, operates under the authority of the Rhode Island 1115 Demonstration Waiver.

Connect Care Choice *Community Partners* option, which is a primary care case management (PCCM) model, operates under the Federal authority of a 1932(a) State Plan Amendment and the Rhode Island 1115 Demonstration Waiver.

Under the authority of RI General Laws Section 40-8.5-1.1, all eligible adult Medicaid beneficiaries and Medicare and Medicaid eligible (MME) beneficiaries, as defined in Section 0375.15 of the MCAR, are offered enrollment in one of the two care management programs: Connect Care Choice *Community Partners* or Rhody Health Options.

Medicaid beneficiaries can choose to remain in Medicaid FFS.

0375.10 Managed Care Program Options for Integrated Care for Adults with Medicare and Medicaid
REV: May 2014

The EOHHS determines the financial eligibility for the RI Medicaid Program, including LTC eligibility and the post-eligibility treatment of income. Financial eligibility is redetermined minimally on an annual basis. As part of the eligibility process, the State LTC staff also develop the initial plan of care, complete the case management assessment forms, authorize services, (including nursing home stays and LTC home and community based services,) and help arrange for the provision of such services at least until the individual is enrolled in one of the managed care options outlined in the following sections.

0375.10.05 Connect Care Choice *Community Partners* Program – Overview
REV: May 2014

Connect Care Choice *Community Partners* (*CCCCP*) is a Primary Care Case Management (PCCM) managed care program for Medicaid-eligible adults and Medicare and Medicaid eligible (MME) beneficiaries.

EOHHS contracts with a Coordinating Care Entity (CCE) which oversees and manages the performance data, quality assurance and quality improvement activities and provides a Community Health Team (CHT) that coordinates the social supports and services for the Medicaid-only and

MME beneficiaries. The CCE coordinates person-centered care management with the existing CCC nurse care managers integrated in the CCC primary care practice sites, the EOHHS Office of Community Programs (OCP) Nurse Care Managers or other staff under the direction of the Division of Elderly Affairs (DEA) for the long term services and supports (LTSS). The CHT provides linkages to social supports for a coordinated, seamless delivery system. For beneficiaries needing LTSS, the LTSS care management and transition services are performed by the state staff including those within the EOHHS Office of Community Programs (OCP) or other staff under the direction of the DEA.

0375.10.10 Rhody Health Options- Overview

REV: May 2014

Rhody Health Options is a statewide managed care program for Medicaid-eligible adults and Medicare and Medicaid eligible (MME) adults, which increases access to health care for adults in the Medicaid Program. Rhody Health Options offers a comprehensive set of medical, mental health, ancillary, LTSS and community support services (such as interpreter services) that are accessible, high quality and focused on primary care, specialty care and chronic care management.

Members receiving Medicaid through the Rhody Health Options program shall be enrolled in a managed care organization (MCO) to coordinate all Medicaid-funded services. The EOHHS contracts with MCOs to provide these health services to beneficiaries.

Rhody Health Options shall integrate the full range of Medicaid services (primary care, acute care, specialty care, behavioral health care and LTSS for all Medicaid-eligible adults, including persons who are dually eligible for Medicaid and Medicare. Certain services for individuals with developmental disabilities and individuals with severe and persistent mental illness (SPMI) shall not be included.

0375.15 Program Eligibility for Rhody Health Options & Connect Care Choice *Community Partners*

REV: May 2014

Rhody Health Options and the Connect Care Choice *Community Partners* Program are available for select populations who are:

1. Residents of Rhode Island;
2. Age twenty-one (21) and older;
3. Medicaid-only clients who receive LTSS; and
4. Medicare beneficiaries who are eligible for full Medicare and Medicaid benefits ("dual eligibles").

0375.15.05 Program Eligibility Exclusion

1. Individuals residing at Tavares, Eleanor Slater or an out-of-state residential hospital; and

2. Individuals currently receiving hospice services shall be excluded. Upon request, beneficiaries who are receiving hospices services may request to be enrolled.

0375.20 Program Enrollment

REV: May 2014

All enrollments into either the Connect Care Choice *Community Partners* or Rhody Health Options Programs shall always be prospective in nature. There shall be no retroactive enrollment into either the Connect Care Choice *Community Partners* or the Rhody Health Options' MCO.

0375.25 Enrollment Process
REV: May 2014

All Medicaid beneficiaries who meet the criteria of either the Connect Care Choice *Community Partners* or Rhody Health Options Programs shall receive written communication from EOHHS that will assign the individual to Connect Care Choice *Community Partners* or Rhody Health Options. This communication will explain the program to the individual and provide instruction on how to change programs or opt-out to FFS. A reasonable timeframe (minimum of thirty days) shall be allowed for the individual to make a decision regarding these options. If a beneficiary does not respond within the above timeframe, the individual shall be enrolled in either Rhody Health Options or Connect Care Choice *Community Partners* Program. Once a beneficiary is enrolled in one of the Programs, the beneficiary shall have the option to change programs on a monthly basis. The requested change will be effective in accordance with the EOHHS enrollment program schedule.

0375.30 Selection of a Managed Care Option

The Connect Care Choice *Community Partners* and Rhody Health Options Programs are voluntary programs. Medicaid beneficiaries are given the option to enroll in one of these programs.

Beneficiaries may change programs or opt-out to FFS. The requested change shall be effective in accordance with the EOHHS program enrollment schedule.

0375.35 Auto Re-Assignment after Resumption of Eligibility
REV: May 2014

Medicaid beneficiaries who are disenrolled from Connect Care Choice *Community Partners* or Rhody Health Options due to a loss of eligibility shall be automatically re-enrolled, or assigned, into the Connect Care Choice *Community Partners* Program or their MCO, should they regain eligibility within sixty (60) calendar days. If more than sixty (60) calendar days has elapsed, the enrollment process shall follow the process in accordance with EOHHS Policy Section 0375.25, Enrollment Process and/or the MCAR section 1311, "Enrollment Process: RIte Care and Rhody Health Partners Managed Care Plans."

0375.40 Member Disenrollment by EOHHS
REV: May 2014

Reasons for EOHHS disenrollment from either the Connect Care Choice *Community Partners* or the Rhody Health Options managed care program participation shall include but shall not be limited to:

1. Death;
2. No longer eligible for Medicaid;
3. Rhody Health Options members no longer eligible for LTSS (Medicaid-only clients);
4. Eligibility error;
5. Placement in Eleanor Slater Hospital, Tavares, or out-of-state residential hospital;

6. Incarceration;
7. Adjudicative action;
8. Changed state of residence;
9. Opt-out to FFS.

0375.45 Requested Member Disenrollment

REV: May 2014

The Connect Care Choice *Community Partners* Coordinating Care Entity (CCE) or Rhody Health Options MCO may request in writing that a member be disenrolled from the program because the member's continued enrollment in the Connect Care Choice *Community Partners* or Rhody Health Options MCO seriously impairs the CCE's or MCO's ability to furnish services to either the particular member or other members. The CCE or Rhody Health Options MCO may not request disenrollment of a member because of:

- An adverse change in the member's health status;
- The member's utilization of medical services; or
- Uncooperative behavior resulting from the member's special needs.

All disenrollments are subject to approval by EOHHS, after an administrative review of the facts of the case has taken place. EOHHS shall determine the disenrollment date as appropriate, based on the results of their review. Members shall be enrolled in one of the managed systems of care for their Medicaid funded services, with the option to opt out to FFS.

0375.50 Formal Grievances and Appeals

0375.50.05 Connect Care Choice *Community Partners* Formal Grievances and Appeals

REV: May 2014

A. Connect Care Choice *Community Partners* members may submit a written request for a fair hearing before the EOHHS Hearing Officer within thirty (30) days of the mailing of the notice of adverse action.

B. The contracted entity (CCE) shall maintain internal policies and procedures to conform to state reporting policies, and shall implement a process for logging formal grievances.

C. Appeals filed with the CCE shall fall into one (1) category:

Non-Medical Care - If the grievance involves a problem other than medical care, the CCE shall decide the grievance within thirty (30) days of all necessary information being received by the CCE.

0375.50.10 Rhody Health Options Formal Grievances and Appeals

A. Rhody Health Options members shall exhaust the internal MCO Level I and Level II appeals process before requesting an EOHHS Fair Hearing.

B. The contracted entity (MCO) shall maintain internal policies and procedures to conform to state reporting policies, and shall implement a process for logging formal grievances.

C. Appeals filed with an MCO fall into three (3) categories:

1. **Expedited** - An MCO shall decide the appeal within seventy-two (72) hours or three (3) business days when a treating provider, such as a doctor who takes care of the member, determines the care to be an emergency and all necessary information has been received by the MCO.

2. **Other Medical Care** - The two levels of non-emergency medical care appeals are as follows:

   a. For the initial level of appeal, the MCO shall decide the appeal within fifteen (15) days of all necessary information being received by the MCO. If the initial decision is adverse to the member, then the MCO shall offer the second level of appeal.

   b. For the second level of appeal, the MCO shall decide on the grievance within fifteen (15) days of all necessary information being received by the MCO.

3. **Non-Medical Care** - If the grievance involves a problem other than medical care, the MCO shall decide the grievance within thirty (30) days of all necessary information being received by the MCO.

D. Rhody Health Options members may also choose to initiate a third level or "external appeal", in accordance with the Rhode Island Department of Health's *Rules and Regulations for the Utilization Review of Health Care Services (R23-17.1-UR).* A member shall not have to exhaust the third level appeal before accessing the EOHHS fair hearing process.

0375.55 Rhody Health Options Benefits
REV: May 2014

The Rhody Health Options Program shall provide a comprehensive benefit package to Rhody Health Options members. The comprehensive Medicaid benefit package shall include Medicaid-funded medically necessary inpatient and outpatient hospital services, physician services, behavioral health services, (including mental health and substance abuse services), family planning services, prescription drugs, laboratory, radiology and other diagnostic services, durable medical equipment, preventive care, and LTSS.

The comprehensive benefit package shall not include LTSS for individuals with SPMI and developmental disabilities funded through the Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH). The MCO shall coordinate with BHDDH providers, but shall not be responsible to deliver or to reimburse for services provided through BHDDH.

It shall not be the responsibility of the MCO to provide out-of-plan benefits that are not included in the capitated payment. These services shall be provided by existing Medicaid-approved providers who are reimbursed directly by Medicaid on a fee-for- service basis.

Prescription drugs shall be a part of the comprehensive benefit package for Medicaid-only clients. Medicare-funded prescription drug coverage shall continue for Medicare-covered prescriptions or any other primary prescription drug plan.

For members of Rhody Health Options, prescription drug benefits shall be administered pursuant to the EOHHS Generics First Policy outlined in policy Sections 0348.45.05.05 and 0374.65.

0375.60 Connect Care Choice *Community Partners* Benefits

REV: May 2014

The Connect Care Choice *Community Partners* Program shall coordinate a comprehensive set of Medicaid State Plan benefits. In addition, the CCE shall be responsible for the coordination of services with the case manager of other service delivery systems outside of the CCE and with the CCE's Community Health Team. The comprehensive set of Medicaid State Plan benefits shall be provided by existing Medicaid-approved providers who are reimbursed directly by Medicaid on a FFS basis.

Prescription drugs shall be a part of the comprehensive benefit package for Medicaid-only clients. Medicare-funded prescription coverage shall continue for Medicare-covered prescriptions or any other primary prescription drug plan.

For members of Connect Care Choice *Community Partners*, Medicaid prescription drug benefits shall be provided pursuant to MCAR section 0300.20.05.35, "Pharmacy Services", the Medicaid formulary, and the generic drug policy outlined in the Medicaid Provider Manual.

It shall be the responsibility of the CCE to coordinate the Medicaid-covered services with the Medicare-covered services.

0375.65 Mainstreaming / Selective Contracting

REV: May 2014

The mainstreaming of Medicaid beneficiaries into the broader health care delivery system is an important objective of the Rhody Health Options Program. The MCO therefore shall ensure that all of its network providers accept Rhody Health Options members for treatment. The MCO shall accept responsibility for ensuring that network providers do not intentionally segregate Rhody Health Options members in any way from other persons receiving services.

The MCO may develop selective contracting arrangements with certain providers for the purpose of cost containment, but shall adhere to the access standards as defined in the health plan contracts.